

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

5344

1. PLACE OF DEATH

County Jackson Registration District No. 404 File No. _____
Township North Washington Primary Registration District No. 53 8-8 Registered No. 12
City St. Louis (No. 8001 Montgall) St. _____ Ward _____

2. FULL NAME

Thannie Lucritia Jewell
(a) Residence. No. 8001 Montgall St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 24 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
12 ✓ ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kan
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER E. C. Jewell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chap
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Margaret Shuck

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pa
(STATE OR COUNTRY) _____

14. INFORMANT E. C. Jewell
(Address) 8001 Montgall

15. FILED Feb 25 1923 B. F. Brannan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1923

17. I HEREBY CERTIFY That I attended deceased from Feb 24 1923 to Feb 25 1923
that I last saw him alive on Feb 24 1923 and that death occurred, on the date stated above, at 7:20 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS

Diphtheria Congruentia
10

CONTRIBUTORY (SECONDARY) same
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IS NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? m DATE OF _____

WAS THERE AN AUTOPSY? m

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. E. Long, M. D.

53 (Address) 1341 Prosper & Co.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Chunwood DATE OF BURIAL Feb 28 23.

20. UNDERTAKER Mrs. E. L. Foster ADDRESS K.C. Mo

K. E. Jewell, M. D., of information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles: Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Jackson State MISSOURI 404 Registered No. _____
Township Washington or Village 5588 _____
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

(a) Residence. No. 8001 Montgall St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX B 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1911

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
12 2 1 31

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country)

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14

Informant _____
(Address)

15

Filed Feb. 28, 1928

11-3154

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1928

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(SECONDARY) _____

18 Where was disease contracted _____ (duration) _____ yrs. _____ mos. _____ ds.
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____, M. D.
_____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

R. F. Prainard REGISTRAR

very ill. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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11—3184

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BY PHYSICIAN.

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